

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30800**
Registrar's No. **8469**

FILED OCT 9 1948

Registration District No. **318**

Primary Registration District No. **100**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Louise Adams

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-30-1050

4. Sex F 5. Color or race negro 6. (a) Single, widowed, married, 2 divorced Widower
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 20 1898
(Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days 7 If less than one day
hr. _____ min. _____

9. Birthplace Tenn (City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Jessie Brown

13. Birthplace Tenn (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Homer G Phillips

(b) Address 2601 Whittier

17. (a) Burial (b) Date thereof 9 29 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oakdale Cemetery

18. (a) Signature of funeral director A. H. Burke

(b) Address 2712 Cass St

19. (a) SEP 29 1948 (b) J. F. Brecker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 212 Plum St (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1948 hour 2 minute a M.

21. I hereby certify that I attended the deceased from 9-18- 19 48 to 9-27 19 48
that I last saw h er alive on Sept. 27 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix, Far Advanced

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature John B. Clayton (M. D. or other) _____

Address 2601 N Whittier Date signed 9/28/48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

No Emb from Hospital to Cemetery A. H. Burk

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.